

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045518

Facility Name: MORTON VILLA CARE CENTER

Address: 190 EAST QUEENWOOD ROAD MORTON 61550
Number City Zip Code

County: TAZEWELL

Telephone Number: (309)266-9741 Fax # (309)866-9376

IDPA ID Number: 36-4438536

Date of Initial License for Current Owners: 07/17/2001

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	BENJAMIN KLEIN	
	(Title)	MANAGER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585	Fax # (847) 675-5777
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,796	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	25,839		5,610	31,449	8
9	SNF/PED					9
10	ICF		3,870		3,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,839	3,870	5,610	35,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.04%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 7/17/2001

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 7/17/2001 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 106 and days of care provided 4,876

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **MORTON VILLA CARE CENTER** # **0045518** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	149,360	5,909	5,898	161,167		161,167		161,167			1
2	Food Purchase		155,939		155,939		155,939	(225)	155,714			2
3	Housekeeping	88,145	17,362		105,507		105,507		105,507			3
4	Laundry	56,878	13,351		70,229		70,229		70,229			4
5	Heat and Other Utilities			108,960	108,960		108,960	1,068	110,028			5
6	Maintenance	36,116	48,788	1,909	86,813		86,813	1,397	88,210			6
7	Other (specify):*			8,891	8,891		8,891		8,891			7
8	TOTAL General Services	330,499	241,349	125,658	697,506		697,506	2,240	699,746			8
	B. Health Care and Programs											
9	Medical Director			8,625	8,625		8,625		8,625			9
10	Nursing and Medical Records	1,438,385	86,971	3,760	1,529,116		1,529,116		1,529,116			10
10a	Therapy	39,849		13,756	53,605		53,605		53,605			10a
11	Activities	68,606	1,978		70,584		70,584		70,584			11
12	Social Services	23,188		2,006	25,194		25,194		25,194			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,570,028	88,949	28,147	1,687,124		1,687,124		1,687,124			16
	C. General Administration											
17	Administrative	45,375		281,492	326,867		326,867	18,530	345,397			17
18	Directors Fees											18
19	Professional Services			33,187	33,187		33,187	5,410	38,597			19
20	Dues, Fees, Subscriptions & Promotions			42,580	42,580		42,580	(23,750)	18,830			20
21	Clerical & General Office Expenses	73,957	12,068	125,225	211,250		211,250	(38,509)	172,741			21
22	Employee Benefits & Payroll Taxes			298,726	298,726		298,726		298,726			22
23	Inservice Training & Education			7,026	7,026		7,026		7,026			23
24	Travel and Seminar							396	396			24
25	Other Admin. Staff Transportation							1,101	1,101			25
26	Insurance-Prop.Liab.Malpractice			74,515	74,515		74,515	347	74,862			26
27	Other (specify):*			90,000	90,000		90,000	(80,073)	9,927			27
28	TOTAL General Administration	119,332	12,068	952,751	1,084,151		1,084,151	(116,548)	967,603			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,019,859	342,366	1,106,556	3,468,781		3,468,781	(114,308)	3,354,473			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,898
	REPAIRS & MAINTENANCE		0
			0
			5,898
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		27,662
	ELECTRICITY		44,499
	WATER		36,799
	CABLE TV - LOBBY		0
			0
			108,960
6	MAINTENANCE		
	GROUNDS MAINTENANCE		1,711
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		0
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		198
			0
			0
			0
			1,909
7	OTHER		
	SCAVENGER		8,891
	SECURITY SERVICE		0
			8,891
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,625
			8,625

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	600
	PHARMACY CONSULTANT	XVIII B 39-2	3,160
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			3,760
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,101
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	6,469
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	186
			13,756
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	2,006
			0
			2,006
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 281,492	281,492
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 0	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 33,187	
		0	33,187
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 18,626	
	EMPLOYEE WANT ADS	XIX F 1,530	
	CONTRIBUTIONS	VI 20 XIX F 200	
	DUES & SUBSCRIPTIONS	XIX F 12,691	
	LICENSES & PERMITS	XIX F 3,210	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 6,323	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	42,580
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,887	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 12,985	
	HOME OFFICE EXPENSE	66,000	
	THEFT & DAMAGE LOSS	1,815	
	TELEPHONE	18,823	
	MESSENGER SERVICE	0	
	COMPUTER MAINTENANCE	17,715	125,225

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 150,465	
	UNEMPLOYMENT COMPENSATION	XIX D 56,327	
	WORKERS COMPENSATION INSURANCE	XIX D 51,859	
	HOSPITALIZATION INSURANCE	XIX D 34,333	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,742	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	298,726
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	7,026	7,026
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	0	0
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	74,515	74,515
27	OTHER		
	BAD DEBTS	VI 24 90,000	
			90,000

GRAND TOTAL COLUMN 3 OTHER 1,106,556

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			16,531	16,531		16,531	(6,044)	10,487			30
31	Amortization of Pre-Op. & Org.							114	114			31
32	Interest			13,709	13,709		13,709	2,825	16,534			32
33	Real Estate Taxes			31,596	31,596		31,596	2,022	33,618			33
34	Rent-Facility & Grounds			349,598	349,598		349,598	4,249	353,847			34
35	Rent-Equipment & Vehicles			8,205	8,205		8,205		8,205			35
36	Other (specify):*											36
37	TOTAL Ownership			419,639	419,639		419,639	3,166	422,805			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,506	442,135	592,641		592,641		592,641			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		150,506	500,329	650,835		650,835		650,835			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,019,859	492,872	2,026,524	4,539,255		4,539,255	(111,142)	4,428,113			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,960)	30		9
10	Interest and Other Investment Income	(62)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(225)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(12,985)	21		18
19	Entertainment		20		19
20	Contributions	(6,523)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,691)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,000)	27		24
25	Fund Raising, Advertising and Promotional	(18,626)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,072)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,930		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,930		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (111,142)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0045518

Report Period Beginning:01/01/2004

Ending:12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2004

[illegible]

Summary B

Facility Name & ID Number	MORTON VILLA CARE CENTER	#	0045518	Report Period Beginning:	01/01/2004	Ending:	12/31/2004
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	HOME OFFICE FEES	\$ 66,000	PLATINUM HEALTH CARE LLC	100.00%	\$	\$ (66,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 66,000			\$	\$ * (66,000)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	PLATINUM HEALTH CARE LLC	100.00%	\$ 1,068	\$ 1,068	15
16	V	6	REPAIRS & MAINTENANCE				1,397	1,397	16
17	V	17	ADMINISTRATIVE SALARY				18,530	18,530	17
18	V	19	PROFESSIONAL FEES				7,101	7,101	18
19	V	20	FEES & SUBSCRIPTIONS				1,377	1,377	19
20	V	21	OFFICE EXPENSES				40,476	40,476	20
21	V	24	EDUCATION & SEMINARS				396	396	21
22	V	25	TRAVEL				1,101	1,101	22
23	V	27	EMPLOYEE BENEFITS				9,927	9,927	23
24	V	26	INSURANCE				347	347	24
25	V	30	DEPRECIATION				1,627	1,627	25
26	V	34	OFFICE RENT				4,249	4,249	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 87,596	\$ * 87,596	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	LICENSES & PERMITS	\$	PHGL, LLC	100.00%	\$ 22	\$ 22	15
16	V	31	AMORTIZATION				114	114	16
17	V	30	DEPRECIATION				6,289	6,289	17
18	V	32	INTEREST				2,887	2,887	18
19	V	33	REAL ESTATE TAXES				2,022	2,022	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 11,334	\$ * 11,334	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN LEVINSON	ADMINISTRATION	SCHEDULE ATTACHED					MGMT FEE	\$ 188,000	17-3	1
2	MARK SHAPIRO	ADMINISTRATION						MGMT FEE	188,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 376,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MORTON VILLA CARE CENTER# 0045518 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PLATINUM HEALTH CARE LLC
Street Address 7444 LONG AVENUE
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847)329-4100
Fax Number (847)329-4900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	471,695	11	\$ 14,258	\$	35,319	\$ 1,068	1
2	6	REPAIRS & MAINTENANCE	" "	471,695	11	18,651		35,319	1,397	2
3	17	ADMINISTRATIVE SALARY	" "	471,695	11	247,477	247,477	35,319	18,530	3
4	19	PROFESSIONAL FEES	" "	471,695	11	94,841		35,319	7,101	4
5	20	FEES & SUBSCRIPTIONS	" "	471,695	11	18,392		35,319	1,377	5
6	21	OFFICE EXPENSES	" "	471,695	11	540,565	398,996	35,319	40,476	6
7	24	EDUCATION & SEMINARS	" "	471,695	11	5,291		35,319	396	7
8	25	TRAVEL	" "	471,695	11	14,698		35,319	1,101	8
9	27	EMPLOYEE BENEFITS	" "	471,695	11	132,583		35,319	9,927	9
10	26	INSURANCE	" "	471,695	11	4,633		35,319	347	10
11	30	DEPRECIATION	" "	471,695	11	21,727		35,319	1,627	11
12	34	OFFICE RENT	" "	471,695	11	56,748		35,319	4,249	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,169,864	\$ 646,473		\$ 87,596	25

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHLG, LLC
Street Address 7444 LONG AVENUE
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847)329-4100
Fax Number (847)329-4900

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	20	LICENSES & PERMITS	CENSUS DAYS	471,695	11	\$ 288	\$	35,319	\$ 22	1
2	31	AMORTIZATION	CENSUS DAYS	471,695	11	1,528		35,319	114	2
3	30	DEPRECIATION	CENSUS DAYS	471,695	11	83,988		35,319	6,289	3
4	32	INTEREST	CENSUS DAYS	471,695	11	38,558		35,319	2,887	4
5	33	REAL ESTATE TAXES	CENSUS DAYS	471,695	11	27,000		35,319	2,022	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 151,362	\$		\$ 11,334	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DR. TOM KLEIN		X	WORKING CAPITAL			79,500				13,709	6
7												7
8	RELATED PARTY	X									2,887	8
9	TOTAL Facility Related						\$ 79,500				\$ 16,596	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$ 79,500				\$ 16,596	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2003 report.				\$	36,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	31,596	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(4,404)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	36,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	31,596	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999		8		
		2000		9		
		2001	13,794	10		
		2002	31,211	11		
		2003	31,596	12		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

MORTON VILLA CARE CENTER

COUNTY

TAZEWELL

FACILITY IDPH LICENSE NUMBER

0045518

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	06-06-29-301-010	NURSING HOME	\$ 31,595.74	\$ 31,595.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 31,595.74	\$ 31,595.74

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,769

B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8					80,381	768		768		768	8
	Improvement Type**										
9	MIXING VALVES / REGULATOR BOARD		2001		1,701	62	27.5	62		238	9
10	WINDOWS		2001		1,528	56	27.5	56		270	10
11	PATIO REPAIR		2001		3,550	129	27.5	129		543	11
12	EMPLOYEE DOOR KEYPADS		2002		4,303	157	27.5	157		440	12
13	ROOF REPAIR		2002		3,620	137	27.5	137		423	13
14	PARKING BLOCKS		2002		9,000	328	27.5	328		1,108	14
15	PAINTING / WALLPAPER		2002		15,914	573	27.5	573		1,738	15
16	HEATING & AIR		2002		2,022	73	27.5	73		223	16
17	HEATING & AIR		2003		4,581	166	27.5	166		242	17
18	STEEL COUNTER FIRE DOOR		2003		1,862	68	27.5	68		99	18
19	WATER HEATER		2004		4,918	82	27.5	82		82	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$133,380	\$2,599		\$2,599	\$	\$6,174	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$28,592	\$3,989	\$2,859	\$(1,130)	10	\$7,638	71
72	Current Year Purchases	16,911	10,711	1,691	(9,020)	10	1,691	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	33,380	7,148	3,338	(3,810)		3,866	74
75	TOTALS	\$78,883	\$21,848	\$7,888	\$(13,960)		\$13,195	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	212,263
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	24,447
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	10,487
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(13,960)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	19,369

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MORTON VILLA NURSING CENTER LTD
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		106	7/18/01	\$ 349,598	15 YRS		3
4	Additions							4
5								5
6								6
7	TOTAL		106		\$ 349,598			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms: AFTER 6/1/09 \$3,074,000
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 8,205
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning 7/18/01

Ending 7/17/16

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	7/18/2005	\$ 349,598
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$			\$ 192,216	\$		\$ 192,216	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				42,727			42,727	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				188,252			188,252	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					150,506		150,506	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
	LAB,RADIOLOGY										
13	Other (specify):						18,940			18,940	13
14	TOTAL			\$			\$ 442,135	\$ 150,506		\$ 592,641	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,615	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 128,253)	916,561		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,933		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX & INS ESCROW	77,924		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,087,033	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	52,999		15
16	Equipment, at Historical Cost	45,503		16
17	Accumulated Depreciation (book methods)	(38,649)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 59,853	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,146,886	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 425,605	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	564,132		29
30	Accrued Salaries Payable	81,670		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,874		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,134,281	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,134,281	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 12,605	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,146,886	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (143,127)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (143,127)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,732	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 155,732	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,605	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,371,851	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,371,851	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	323,074	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 323,074	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,694,987	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	697,506	31
32	Health Care	1,687,124	32
33	General Administration	1,084,151	33
	B. Capital Expense		
34	Ownership	419,639	34
	C. Ancillary Expense		
35	Special Cost Centers	592,641	35
36	Provider Participation Fee	58,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,539,255	40
41	Income before Income Taxes (line 30 minus line 40)**	155,732	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 155,732	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,968	2,080	\$ 52,627	\$ 25.30	1
2	Assistant Director of Nursing	1,816	2,080	59,918	28.81	2
3	Registered Nurses	12,792	13,419	340,235	25.35	3
4	Licensed Practical Nurses	13,998	14,621	331,856	22.70	4
5	Nurse Aides & Orderlies	52,746	55,696	626,778	11.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,881	3,445	39,849	11.57	8
9	Activity Director	1,860	1,950	23,269	11.93	9
10	Activity Assistants	4,120	4,688	45,337	9.67	10
11	Social Service Workers	1,749	1,876	23,188	12.36	11
12	Dietician					12
13	Food Service Supervisor	1,830	2,058	30,224	14.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,675	14,299	119,136	8.33	15
16	Dishwashers					16
17	Maintenance Workers	1,951	2,176	36,116	16.60	17
18	Housekeepers	8,129	9,060	88,145	9.73	18
19	Laundry	6,421	7,089	56,878	8.02	19
20	Administrator	1,838	1,950	45,375	23.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,552	6,043	73,957	12.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,658	1,805	26,971	14.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,984	144,335	\$ 2,019,859 *	\$ 13.99	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 5,898	1-3	35
36	Medical Director	MONTHLY	8,625	9-3	36
37	Medical Records Consultant	8	600	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	3,160	10-3	39
40	Physical Therapy Consultant	169	7,101	10a-3	40
41	Occupational Therapy Consultant	154	6,469	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	4	186	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	38	2,006	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	493	\$ 34,045		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$5438
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,194
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees